Instructions for Completion of Grievance and Appeal Log

The Complaint and Grievance Log is a mechanism of documenting and tracking complaints/grievances submitted by recipients or providers. It is an at-a-glance record of complaints from registration until resolution. It is maintained by the Primary Contractor and is submitted to the Medicaid QI Division quarterly. After grievances are logged in on the grievance log, the Primary Contractor will e-mail the Maternity Care Associate Director within three working days of the grievance stating recipient name, Medicaid number, nature of grievance and disposition of grievance.

Document appeals process and fair hearing process discussed with recipient.

All appeal resolutions must be provided will be notified in writing to the recipient by the Primary Contractor.

Items to be recorded are identified by column headers and are self-explanatory. A more detailed explanation of the codes required follows:

Complaint Codes

A. **Staff** – can refer to problems or conflicts with staff in MD office, hospital, other medical facilities or care coordination.
B. **Medical/MD** – refers to concerns related to care provided by MD or other medical professionals.
C. **Environment** – refers to issues related to MD office, hospital or other facilities encountered by the recipient.
D. **Billing** – refers to coverage and payment issues encountered by the recipient
E. **Communication** – refers to any problems encountered by the recipient related to the timely transmission of information from those involved in providing prenatal care.
F. **Time** – refers to any issues the recipient has related to time spent waiting for MD or Care Coordinator, scheduling issues, etc.
G. **Transportation** – any difficulties related to transportation to MD visits, other health visits required due to pregnancy, etc.
H. **Other** – refers to any complaint or issue not identified in the above codes.

Resolution Codes

A. **Resolved:** issue resolved satisfactorily between recipient and those involved.
B. **Unresolved – additional action needed**: issue has not been resolved and may require referral to the Grievance Committee.
C. **Unresolved – appeal process**: issue has not been resolved satisfactorily by the Grievance Committee and the recipient appeals for further action.
D. **Unresolved – fair hearing:** the recipient does not accept issue resolution and requests a fair hearing with Medicaid.

Level Codes

A. **S – Standard:** resolved within 90 days.
B. **E – Expedited:** requires more immediate resolution within 48 hours.